Add a Person Form

To add people in your household to Healthy Families

Instructions

- Use this form for any people in your home you would like to add to Healthy Families. To add more than 4 people, copy this form.
- Use this form for unborn children who are due to be born within 90 days. Send with this form a copy of your pregnancy certificate that shows the estimated date of delivery. After a baby is born, mail a copy of the birth document to Healthy Families within 30 days. Coverage for the baby will start 13 days after we get the document.
- For each person who is a U.S. citizen or national, you must **send a copy of a birth certificate within 2 months.** For people who are not U.S. citizens or nationals, you must send **proof of immigration status within 2 months.**

Questions?

If you have any questions about the form, call Healthy Families: ***1-866-848-9166****, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m.*

The call is free.

Family Member Number:

People to add ➡		Person 1	Person 2	Person 3	Person 4
Name ➡	First name				
	Middle name				
	Last name				
Birth name ➡ *(if different from name above)*	First name				
	Middle name				
	Last name				
Address ➡ *(if different from applicant's)*	Street				
	City				
	Zip Code				
Relationship to applicant					
Sex		❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of birth *(or expected date)*					
Birth place (California county, other state or other country)					

Questions about these persons continue on next page.

People to add, ***continued*** ➨		**Person 1**	**Person 2**	**Person 3**	**Person 4**
Ethnicity What is the ethnic (cultural) background of each person?		❑ White ❑ Hispanic ❑ Black/African American ❑ Asian ❑ American Indian ❑ Alaskan Native ❑ Filipino ❑ Amerasian ❑ Chinese ❑ Cambodian ❑ Japanese ❑ Samoan ❑ Asian Indian ❑ Hawaiian ❑ Guamanian ❑ Laotian ❑ Vietnamese ❑ Korean ❑ Other	❑ White ❑ Hispanic ❑ Black/African American ❑ Asian ❑ American Indian ❑ Alaskan Native ❑ Filipino ❑ Amerasian ❑ Chinese ❑ Cambodian ❑ Japanese ❑ Samoan ❑ Asian Indian ❑ Hawaiian ❑ Guamanian ❑ Laotian ❑ Vietnamese ❑ Korean ❑ Other	❑ White ❑ Hispanic ❑ Black/African American ❑ Asian ❑ American Indian ❑ Alaskan Native ❑ Filipino ❑ Amerasian ❑ Chinese ❑ Cambodian ❑ Japanese ❑ Samoan ❑ Asian Indian ❑ Hawaiian ❑ Guamanian ❑ Laotian ❑ Vietnamese ❑ Korean ❑ Other	❑ White ❑ Hispanic ❑ Black/African American ❑ Asian ❑ American Indian ❑ Alaskan Native ❑ Filipino ❑ Amerasian ❑ Chinese ❑ Cambodian ❑ Japanese ❑ Samoan ❑ Asian Indian ❑ Hawaiian ❑ Guamanian ❑ Laotian ❑ Vietnamese ❑ Korean ❑ Other
U.S citizen or national?		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If no, write date of entry into U.S.					
Social Security Number: *(You do not have to write this)*					
Mother's name ➨	First name				
	Last name				
Does the mother live in the home?		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Father's name ➨	First name				
	Last name				
Does the father live in the home?		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If the person earns income, how much per month? *See the **Family Members and Income** brochure about what to list.*		$ From where?	$ From where?	$ From where?	$ From where?
Does this person have no-cost Medi-Cal?		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, give date coverage will end					

Questions about these persons continue on next page.

Questions? Call 1-866-848-9166, *Monday to Friday, 8 a.m. to 8 p.m., or Saturday, 8 a.m. to 5 p.m. The call is free.*

People to add, ***continued*** ➨	Person 1	Person 2	Person 3	Person 4
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Did this person have health insurance from an employer in the last 90 days? If yes, check the main reason why insurance stopped.	❑ lost or changed job ❑ moved, no insurance available ❑ employer ended benefits to all employees ❑ COBRA coverage ended ❑ reached maximum coverage of benefits ❑ death, legal separation or divorce ❑ other: __________	❑ lost or changed job ❑ moved, no insurance available ❑ employer ended benefits to all employees ❑ COBRA coverage ended ❑ reached maximum coverage of benefits ❑ death, legal separation or divorce ❑ other: __________	❑ lost or changed job ❑ moved, no insurance available ❑ employer ended benefits to all employees ❑ COBRA coverage ended ❑ reached maximum coverage of benefits ❑ death, legal separation or divorce ❑ other: __________	❑ lost or changed job ❑ moved, no insurance available ❑ employer ended benefits to all employees ❑ COBRA coverage ended ❑ reached maximum coverage of benefits ❑ death, legal separation or divorce ❑ other: __________
Write date insurance stopped.				

Adults in the household

Name of adult	Relationship to applicant	Relationship to children	Gross income amount (income before taxes)	How often is the person paid?
	Applicant		$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

Expenses

Childcare expenses you pay each month for children under age 2. The maximum amount allowed is $200 per child.	$ Send proof of expense
Childcare expenses you pay each month for children age 2 and over. The maximum amount allowed is $175 per child.	$ Send proof of expense
Disabled dependent care expenses you pay each month. The maximum amount allowed is $175 per person receiving care.	$ Send proof of expense
Monthly court ordered alimony you pay.	$ Send proof of expense
Monthly court ordered child support you pay.	$ Send proof of expense
For each working parent, we will deduct up to $90 for work-related expenses.	
Is the applicant or anyone else in the home pregnant? ❑ Yes ❑ No If yes, name? _____	

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature: _____ **Date:** _____

Permission to forward Add a Person Form to Medi-Cal: If this person/child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of anyone applying for full scope Medi-Cal benefits.

Applicant Signature: _____ **Date:** _____

Permission to share information with the following person:

I give permission for the Healthy Families Program and Medi-Cal Program to give information over the telephone about the status of this application to a Certified Application Assistant of the Enrollment Entity organization identified. This permission will end on the date the program mails the results of the eligibility determination on this application.

Name: _____

CAA#: _____ **EE#:** _____

➨ **Applicant Signature:** _____ **Date:** _____